THE PRIMARY CARE COMPANION FOR CNS DISORDERS

Supplementary Material

Article Title: Use of Bright Light Therapy Among Psychiatrists in Massachusetts: An E-Mail Survey

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Disclaimer

This Supplementary Material has been provided by the author(s) as an enhancement to the published article. It has been approved by peer review; however, it has undergone neither editing nor formatting by in-house editorial staff. The material is presented in the manner supplied by the author.

Bright Light Therapy Survey

This survey is hosted by Acrobat FormsCentral, and all data submitted below is sent to a secure account there.

Do you recommend bright light therapy (BLT) to your patients

- ◯ Yes
- ◯ No

For how long have you been recommending BLT?

Do you recommend the use of BLT to patients with seasonal affective disorder (SAD)?

- ◯ Yes
- ◯ No

To what portion of your patients with SAD do you recommend BLT?

How long does it usually take for clinical response to BLT in SAD?

Do you recommend the use of BLT to patients with non-seasonal major depression (NS-MD)?

- ◯ Yes
- ◯ No

To what portion of your patients with NS-MD do you recommend BLT?

How long does it usually take for clinical response to BLT in NS-MD?

How long do you recommend a patient use BLT in a single treatment period?

- ◯ 1 week
- ◯ 2 weeks
- ◯ Longer

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Do you recommend BLT for inpatients, outpatients, or both?
If both, check both boxes.

- ☐ Inpatients
- ☐ Outpatients

The following three questions pertain to the type of BLT you recommend.

What light delivery device do you recommend (*e.g.,* box, visor, pad, etc.)?
Specify make and model if known.

What light intensity do you recommend?

- ○ 2,500 lux
- ○ 10,000 lux
- ○ Other

What session duration do you recommend?

- ○ 30 minutes
- ○ 2 hours
- ○ Other

Which of the following limit(s) your use of BLT?

- ☐ Limited efficacy
- ☐ Not approved by the FDA
- ☐ Not on treatment algorithms
- ☐ Unclear mechanism of action
- ☐ Not covered by insurance
- ☐ Limited knowledge of BLT
- ☐ Patient preference
- ☐ Cumbersome to use
- ☐ Patient compliance concerns
- ☐ Other(s)

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For each of the following conditions (ICD-9 codes in parentheses), please indicate whether you consider BLT efficacious as **monotherapy**.

	Yes	No
Non-seasonal major depressive disorder, single episode (296.2)	○	○
Non-seasonal major depressive disorder, recurrent (296.3)	○	○
Seasonal affective disorder (296.3) *(Major depressive disorder, recurrent, with seasonal pattern)*	○	○
Sub-syndromal seasonal affective disorder (311) *("Winter blues")*	○	○
Negative symptoms in schizophrenia (295)	○	○
Neurotic,* stress-related,** and somatoform disorders (300s) **Primary anxiety disorders* ***Post-traumatic and acute stress disorders*	○	○
Primary (non-organic) sleep disorders (307.4)	○	○
Jet lag syndrome (307.45) *(Circadian rhythm sleep disorder, jet lag type)*	○	○

Please indicate any other conditions in which you consider BLT efficacious as **monotherapy**.

For each of the following conditions (ICD-9 codes in parentheses), please indicate whether you consider BLT efficacious as **adjunctive treatment**.

	Yes	No
Non-seasonal major depressive disorder, single episode (296.2)	○	○
Non-seasonal major depressive disorder, recurrent (296.3)	○	○
Seasonal affective disorder (296.3) *(Major depressive disorder, recurrent, with seasonal pattern)*	○	○
Sub-syndromal seasonal affective disorder (311) *("Winter blues")*	○	○
Negative symptoms in schizophrenia (295)	○	○
Neurotic,* stress-related,** and somatoform disorders (300s) **Primary anxiety disorders* ***Post-traumatic and acute stress disorders*	○	○
Primary (non-organic) sleep disorders (307.4)	○	○
Jet lag syndrome (307.45) *(Circadian rhythm sleep disorder, jet lag type)*	○	○

Please indicate any other conditions in which you consider BLT efficacious as **adjunctive treatment**.

The following questions request demographic data.
We emphasize that these data are optional. They will be used anonymously and only for statistical purposes.

Which of the following describes your current level of training?

○ Resident
○ Attending
○ Other

What percent of your practice is outpatient?

What percent of your practice is inpatient?

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Which of the following, if any, best describes your practice?

- ◯ Urban
- ◯ Suburban
- ◯ Rural

Including residency, how long have you practiced medicine (in years)?

Please identify your gender.

- ◯ Male
- ◯ Female
- ◯ Other/Deferred

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